STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445130	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SPARTA	34 GRACEY ST SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide two residents (#68, #58) choices of the frequency of showers per week, for thirty-three residents reviewed. The findings included: Resident #68 was admitted to the facility on August 28, 2010, with diagnoses including Depression, Alzheimer's Dementia, Atrial Fibrillation, and Congestive Heart Failure. Medical record review of a quarterly Minimum Data Set (MDS) dated February 24, 2013, revealed the resident was cognitively intact and independent with one assist for Activities of Daily Living (ADL's). Medical record review of a care plan dated April 30, 2013, revealed the resident required assistance with bathing and dressing as needed. Observation and interview with resident #68 on May 7, 2013, at 10:00 a.m., in the resident's	F 242	This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of NHC HealthCare Sparta as to the accuracy of the surveyor's findings nor the conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of the facility that the findings are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. F 242 – Self-Determination – Right to make choices On May 8th resident number #58 and #68 were offered a shower and asked how many times per week, what days and times they would prefer showers. On May 15th all alert residents in the facility were interviewed about when they would like showers and schedule was adjusted per their preference. As new residents are admitted into the facility we will add them to the shower list according to their preference. All staff was in-serviced on 5-15-13 on resident's right to make choices. Director of Nursing or designee will monitor compliance of resident choices weekly x 8. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	5-15-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Stephens	Administrator	5-15-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 room, revealed the resident's clothes on the chair, and the resident dressed in a gown sitting on the bed. Continued interview revealed the resident had been waiting on Hospice to give the resident a shower. Further interview revealed the resident had been given two showers per week and would like to have a shower every day. Interview with Registered Nurse (RN) #1 on May 8, 2013, at 8:14 a.m., in the Unit Two Nurse's Station, revealed the residents are scheduled two showers per week per room number. Continued interview revealed resident #68's showers had been scheduled on Tuesday and Friday and Hospice performed showers on Tuesday. Interview with RN #1 on May 8, 2013, at 8:21 a.m., in the Station Two Nurse's Station, revealed RN #1 asked the resident how often the resident would like a shower and the resident responded every day. Further interview confirmed the resident had not been given a choice on how often to shower. Resident #58 was admitted to the facility on May 8, 2007, with diagnoses including Psychosis, Hypertensive Cardiovascular Disease, Agitation, Alzheimers, Parkinsons, Depression, Anxiety, and Chronic Obstructive Pulmonary Disease, Medical record review of a Significant Change Minimum Data Set (MDS) dated October 15, 2012, revealed the resident required extensive assistance with personal hygiene and bathing and, for preferences, it was very important to the resident to be able to choose between a tub bath, shower, bed bath, or sponge bath.	F 242		

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F 242	Continued From page 2 Medical record review of the Care Plan dated January 10, 2013, revealed, "...Hospice Services provides bathing/grooming two days per week and facility staff provides the rest of the time..." Observation of and interview with the resident on May 6, 2013, at 8:10 a.m., in the resident's room, revealed the resident was sitting in a recliner and stated did not get to choose how many times a week showers or baths were given or the type of bath given. Further interview revealed the facility provided two showers per week and baths in the recliner on the other days. Further interview revealed the resident did not recall ever being asked preferences regarding bathing but would like three showers a week. Interview with Certified Nurse Aide #1 on May 7, 2013, at 3:05 p.m., in the breakroom, confirmed the facility had a shower schedule for residents. The residents were assigned and received two showers per week and sponge or bed baths on the other days. Interview with Registered Nurse #1 on May 8, 2013, at 9:04 a.m., at the Unit 2 nursing station, and review of shower schedules, confirmed all the residents were assigned two showers a week on the shower schedule by room number, Further interview confirmed residents were not asked preferences for how many days a week or what days/times they would like showers when making the shower schedules.	F 242		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 3 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain a safety device for one resident (#90) of thirty-three residents reviewed. The findings included: Resident #29 was admitted to the facility on March 1, 2010, with diagnoses including Dementia, Paranoid, Anxiety, Hypertension, and History of Personal Falls. Medical record review of the care plan dated May 7, 2013, revealed chair alarm while up in chair. Observation on May 7, 2013, at 3:40 p.m. revealed the resident sitting in a wheelchair, propelling self in hallway, and a safety alarm device attached to the back of the resident's chair. Continued observation revealed the resident stood up and the safety alarm did not sound. Interview with the Licensed Practical Nurse #1 on May 7, 2013, at 3:43 p.m., at the Unit Three Nurse's Station, confirmed the safety device had not been placed on the resident correctly and the safety device failed to alarm.	F 323	F 323 – Free of Accident Hazards/Supervision/Devices On 5-7-13 the alarm on resident # 90 was corrected so it would work properly. All other residents with alarms in place were evaluated to make sure they were working properly on 5-15-13. New types of alarms are being evaluated to determine if different types of alarms would be beneficial. All staff was in-serviced on 5-15-13 on alarms and proper usage. Director of Nursing will monitor alarm function weekly x 8. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	5-15-13
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=C	Continued From page 4 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the correct nurse staffing was posted.	F 356	F 356 – Posted Nurse Staffing On 5-6-13 the staffing posted at each nursing unit was corrected to reflect the correct date on all three units. All licensed staff was in-serviced on 5-15-13 on making sure the correct information is posted. Director of Nursing or designee will monitor compliance of posted nurse staffing weekly x 8. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	5-15-13

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F 356	Continued From page 5 The findings included: Observation on initial tour May 6, 2013, at 5:30 a.m., revealed staffing posted at each nursing unit dated May 3, 2013. Interview with Licensed Practical Nurse (LPN) #8 on May 6, 2013, at 5:30 a.m., at the Unit Three nursing station confirmed the staffing posted was dated May 3, 2013. Interview with LPN #9 on May 6, 2013, at 5:40 a.m. at the Unit One nursing station confirmed the staffing posted was dated May 3, 2013.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to store, prepare, and distribute food under sanitary conditions. The findings included:	F 371	F 371- Food Procure, Store/Prepare/Serve – Sanitary On 5-6-13 the twenty-five pound bag of flour, twenty-five pound box of thickener and two boxes of supplements were moved at least six inches off the floor. All other storage areas were check to make sure no other items were stored on the floor. On 5-15-13 all dietary staff was in-serviced about proper food storage. Dietary manager or his designee will monitor proper food storage weekly x 8. On 5-6-13 the reach in cooler was taken out of commission. On 5-7-13 a new reach in cooler was put in place. On 5-7-13 all other coolers were checked to verify that the thermometers were 41 degrees or lower. On 5-15-13 all dietary staff was in-serviced on proper milk temperatures. Dietary manager or his designee will monitor proper milk temperatures weekly x 8. On 5-6-13 the fifty gallon gray trash can was moved and replaced with a foot pedal garbage can. On 5-15-13 new foot pedal garbage cans were ordered to replace all existing garbage cans in the food prep area. On 5-15-13 all dietary staff was in-serviced on the proper way to discard trash and hand washing. Dietary manger or his designee will monitor proper garbage disposal weekly x 8.	5-15-13

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F 371	Continued From page 6 Observation on May 6, 2013, at 8:00 a.m., in the kitchen storage, revealed a twenty-five pound bag of flour, a twenty-five pound box of thickener ½ full, and two boxes containing six thirty-two ounce containers of two cal supplements stored on the floor. Review of the facility's policy Dry Storage dated April 2003, revealed, "...items will be stored at least six inches off the floor..." Interview with the Dietary Manager on May 6, 2013, at 8:00 a.m., in the kitchen storage, revealed the twenty-five pound bag of flour, a twenty-five pound box of thickener ½ full, and two boxes containing six thirty-two ounce containers of two cal supplements stored on the floor. Further interview confirmed the facility failed to store the food items off of the floor. Observation on May 6, 2013, at 11:20 a.m., in the Dietary Department, revealed the thermometer in the reach in cooler registered forty-two degrees. Further observation revealed the Dietary Manager performed a temperature on a pint of milk stored in the reach in cooler and the temperature had been 44.6 degrees. Review of the facility's policy Time and Temperature Control revised January 2011, revealed, "...cold foods will be held at 41 degrees Fahrenheit or lower..." Interview with the Dietary Manager on May 6, 2013, at 11:23 a.m., in the Dietary Department, confirmed the facility failed to store the milk below forty-one degrees.	F 371	F371 cont. On 5-6-13 the milk crate was removed from the elevator and a clean ladder rack was put in place to transfer trays from the kitchen to the units. On 5-15-13 all staff was in-serviced on the correct way to transfer trays from the kitchen to the units. Dietary manager or his designee will monitor proper transportation of trays weekly x 8. On 5-6-13 the chopped pork was thrown out and was replaced with new chopped meat that was the appropriate temperature. The pureed pork was heated to bring back up to proper temperature. Temperatures were checked on all other food items at that time to verify that they were at the proper level. Upon further examination it was determined that the steam table that was being used to serve the chopped and pureed pork had a heating element that was not functioning properly. The steam table was taken out of commission until repairs can be made to it. On 5-15-13 all dietary staff was in-serviced on proper food temperatures. Dietary manager or his designee will monitor proper food temperatures weekly x 8. Findings from the above quality assurance monitors will be reported by the Administrator to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manger, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	

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F 371	Continued From page 7 Observation on May 6, 2013, at 11:42 a.m., in the Dietary Department, revealed Dietary Aide #1 washed the hands, opened the lid on the fifty gallon gray trash can with the hands, disposed of the paper towel in the trash can, shut the lid, and continued to handle cooking utensils without rewashing the hands. Interview with the Dietary Manager on May 6, 2013, at 11:45 a.m., in the Dietary Department, confirmed the gray trash can had been dirty, and no step can had been provided at the hand wash sink. Observation on May 6, 2013, at 11:50 a.m., in the Dietary Department, revealed Dietary Aide #1 opened the elevator, placed a resident tray on a milk crate in the elevator, and sent it to the floor for resident use. Observation and interview with the Dietary Manager on May 6, 2013, at 11:53 a.m., in front of the elevator, confirmed the milk crate had been dirty, and the tray should not be served to the resident. Observation with Dietary Aide #1 on May 6, 2013, at 12:15 p.m., in the Station One Dining Room, revealed chopped pork 119 degrees, and pureed pork at 121 degrees. Interview with the Dietary Aide #1 on May 6, 2013, at 12:16 p.m., in the Station One Dining Room, revealed two trays had been served with chopped pork and one tray of pureed pork had been served.	F 371		

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F 371	Continued From page 8 Interview with the Dietary Manager on May 6, 2013, at 12:17 p.m., in the Station One Dining Room, confirmed the pork had been served below the required temperature of 140 degrees. Interview with the Administrator on May 8, 2013, at 10:30 a.m., in the Administrator's Office, confirmed the Dietary Department should have step trash cans at the hand washing sink, and the milk temperature should be at least forty-one degrees.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F 431 – Drug Records, Label/store drugs & Biological. On 5-6-13 LPN #1 returned to the room and removed the insulin pen from the over bed table. All other rooms were checked to make sure medications were not left in the room. On 5-15-13 all licensed staff was in-serviced on not leaving medications at bed side. The Director of Nursing or her designee will monitor medication administration weekly x 8. On 5-8-13 the Ativan stored in the medication storage room on unit three nursing station was moved to a lockable refrigerator. On 5-8-13 the lock box on station two nursing station was locked once it had been identified as not being locked. On 5-8-13 Network Pharmacy was contacted to order a new lock box for Unit three. New box was received and installed on 5-15-13. On 5-15-13 all licensed staff was in-serviced on the proper storage of controlled substance. The Director of Nursing or designee will monitor compliance of proper controlled substance weekly x 8.	5-15-13

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F 431	Continued From page 9 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview the facility failed to store medications safely and securely. The findings included: Observation with Licensed Practical Nurse (LPN) #1 on May 6, 2013, at 7:00 a.m., during a random medication pass, revealed the LPN administered an injection of Byetta (insulin pen), placed the insulin pen on the resident's over bed table, and left the room. Review of facility policy Medication Storage in the Facility dated October 2011, revealed "...only licensed nurses...and those authorized to administer medications are allowed access to medications..." Interview with LPN #1 on May 6, 2013, at 7:15 a.m., in the 100 hallway, confirmed the LPN had not stored the insulin pen according to the facility's policy and procedure for medication	F 431	F 431 cont. On 5-8-13 the "Shift Drug Count Records" were reviewed. On 5-15-13 all licensed staff was in-serviced on the proper way to document on the "Shift Drug Count Record." The Director of Nursing or designee will monitor compliance of proper documentation on the "Shift Drug Count Record" weekly x 8. Findings of the quality assurance monitors will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurses, Facility Rehab Coordinator and Wound care Nurse.	5-15-13

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F 431	Continued From page 10 storage. Observation on May 8, 2013, at 8:45 a.m., of the medication storage room on unit two nursing station revealed a lock box in the medication refrigerator that was not locked. The lock box contained two vials of Ativan for injection. Interview on May 8, 2013, at 8:45 am, with the Licensed Practical Nurse (LPN) #3, in the medication storage room on unit two nursing station, confirmed the lock box was not locked. Observation on May 8, 2013, at 9:05 a.m., in the medication storage room on unit three nursing station revealed a lockable medication refrigerator that was not locked. The medication refrigerator contained two vials of Ativan for injection in a drawer within the refrigerator. Interview with LPN #5 on May 8, 2013, at 9:05 a.m., in the medication storage room on unit three nursing station, confirmed the medication refrigerator was not locked. Interview with LPN #4 on unit two long hall on May 8, 2013, at 9:15 a.m., confirmed the lock box in the medication storage room that contains Ativan "should be locked." Interview with LPN #6 and LPN #7 on unit one nursing station in the medication storage room on May 8, 2013, at 10:05 a.m., confirmed "Ativan is always in the lock box." Record review of the facility policy "Medication Storage in the Facility" for "controlled substance storage" revealed " ...medications subject to	F 431		

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F 431	Continued From page 11 abuse or diversion are stored in a ...double-locked compartment separate from all other medications ...controlled substances that require refrigeration are stored within a locked box within the refrigerator ..." Observation of the "Shift Drug Count Record" on the unit two long hall medication cart on May 8, 2013, at 9:15 a.m., revealed the April 2013, record did not have signatures for count until April 15, 2013, and then had ten blank spaces between April 15, 2013, and April 20, 2013. The "Shift Drug Count Record" on the unit two long hall medication cart for May, 2013, revealed five blank spaces between May 1, 2013, and May 8, 2013. Interview with LPN #4 on May 8, 2013, at 9:15 a.m., in the unit two long hallway, confirmed the "Shift Drug Count Record" is to be signed by oncoming and off going nurse at the change of each shift and the record was incomplete. Observation of the "Shift Drug Count Record: on the unit one long hall medication cart on May 8, 2013, at 10:05 a.m., revealed the May 2013, record did not have signatures in six spaces. Interview with LPN #6 on May 8, 2013, at 10:05 a.m., at the unit one nursing station confirmed the "Shift Drug Count Record" was incomplete.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445130	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and	F 441	F 441 – Infection Control, Prevent Spread, Linens On 5-6-13 LPN # 1 washed hands after the medication was given. All licensed staff was in-serviced on 5-15-13 on when hands have to be washed during medication pass. Director of Nursing or designee will monitor compliance of proper hand washing during medication pass weekly x 8. Findings of the quality assurance monitors will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	5-15-13

MAY 17 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 13 interview, the facility failed to follow infection control policies during a random medication pass on one of three halls. The findings included: Observation on May 6, 2013, at 7:00 a.m., during a random medication pass, with Licensed Practical Nurse (LPN) #1, revealed the LPN administered a Novolog (insulin) injection to a resident, disposed of the syringe in the sharps container, administered a second injection of Byetta (insulin), changed gloves, applied the clean gloves (without washing hands), and then administered eleven pills by placing them in the resident's mouth. Observation with LPN #1 on May 6, 2013, at 7:15 a.m., in the 100 hallway, revealed the LPN cut a pill in half, disposed of the 1/2 pill in the sharps container, and administered the medications to the resident without washing the hands. Review of the facility's policy Handwashing revised October 2008, revealed "...hand hygiene...is an essential element of Standard Precautions...wash hands...before and after removal of gloves..." Interview with the LPN #1 on May 6, 2013, at 7:20 a.m., in the 100 hallway, confirmed the LPN failed to wash the hands after touching the "very dirty" sharps container.	F 441		